1988

ANA Convention, 1988; Series I; File 10

Juanita Hunter

#10

A.N.A. CONVENTION

1988

Martha L. Orr, MN, RN
Executive Director

Constituent of The American Nurses Association

NEW YORK STATE NURSES ASSOCIATION
2113 Western Avenue, Guilderland, N.Y. 12084, (518) 456-5371

March 11, 1988

Mary E. Stainton
Chairperson
Reference Committee
American Nurses' Association
2420 Pershing Road
Kansas City, MO 64108

Dear Ms. Stainton:

The New York State Nurses Association Board of Directors submits the enclosed proposal to the 1988 ANA House of Delegates on the subject of: The Legitimate Role of ANA for Credentialing in Nursing. The proposal was developed in accordance with the provisions of ANA's Procedures for Submission of Proposals. It is a reaffirmation of ANA position and policy.

Thank you for the opportunity to submit proposals to the House.

Sincerely yours,

Juanita K. Hunter, EdD, RN
President

Enclosure

JKH:WMB:b

cc: Board of Directors

1988 HOUSE OF DELEGATES

SUBJECT: The Legitimate Role of ANA for Credentialing in Nursing

INTRODUCED BY: Board of Directors
New York State Nurses Association

Rationale

In January of 1979, the ANA Board of Directors received the report of the committee on The Study of Credentialing in Nursing: A New Approach. One of the five recommendations of the committee concerned the establishment of a national nursing credentialing center. A task force was subsequently appointed to implement the recommendations. Two and one-half years of work focused primarily on the one recommendation related to a credentialing center.

The task force identified 15 voluntary national organizations to become a coalition to implement the national nursing credentialing center. The American Nurses Association, the National League for Nursing and other nursing organizations could not agree on the proposal.

Throughout the years since 1979, every House of Delegates has addressed concerns about credentialing in nursing.

In the 1983 ANA Philosophy on Credentialing it is stated:

> "As the national organization that encompasses all nursing arenas, ANA has a preeminent view of national nursing needs and a capacity to generate a broad-based representation of nursing. Thus, ANA believes that it is uniquely qualified to set standards for nursing practice, nursing education and organized nursing services, and to operationalize criteria and judge conformity to standards, thereby orchestrating a coherent national credentialing system for nursing."

It further states:

> "The American Nurses' Association representing the nursing profession accepts through its bylaws, responsibility for ensuring a coherent credentialing system for the profession. The ANA House of Delegates authorizes the association to conduct programs which are part of this system. ANA collaborates with other organizations that regulate or influence credentialing activities."

In 1984, the ANA Board of Directors, in three separate actions, postponed, tabled and rejected [illegible] separately incorporated credentialing center. In 1985, the ANA Board of Directors presented the rationale for this decision to the House of Delegates. The 1985 House of Delegates approved the action to retain the Center for Credentialing Services as an administrative unit within ANA.

In 1986 and 1987, the House of Delegates spent innumerable hours debating the [illegible] plan for the association. Goal III, "Develop a cohesive system for credentialing [illegible] the American Nurses' Association to divest itself of credentialing activities," [illegible]

- to provide services to SNAs
- to provide certification
- to provide for recognition of ANA standards
- to implement a system of accreditation of continuing education
- to establish ANA's function in accreditation of nursing programs

Now again, there is the promulgation of Guidelines for Establishment of a National Institute for Credentialing in Nursing apart from ANA. These Guidelines, authorizing responsibilities to the ANA Board of Directors by January 1, 1989, have been put forth outside the usual process for such [illegible] from the boards, cabinets, committees, councils, SNAs and this House of Delegates. The Guidelines [illegible] goals of the constituents and represent the opinions of a minority element.

Nine years of discussion and debate on this one issue is enough. ANA must [illegible] credentialing system for nursing to achieve the goal of safe practice [illegible] be consistent with society's expectation that the nursing profession will be [illegible]

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Recommendations

Recommendation #1

That this House of Delegates reaffirm the 1983 Philosophy Statement declaring ANA's sole and fundamental authority as the credentialing agent for the nursing profession.

Recommendation #2

That the American Nurses' Association representing the nursing profession assert its highest responsibility for ensuring a coherent credentialing system for the profession, and

Recommendation #3

That the American Nurses' Association Board of Directors apprise all appropriate cabinets, commissions, councils, SNAs and future Houses of Delegates of any intent to incorporate credentialing activities apart from ANA before any such action is initiated.

Past House Actions

1980 . Resolution on Credentialing in Nursing

1982 . ANA Board of Directors motion to establish a separately incorporated center for professional assessment and evaluation...
. Association Priority D - Develop a Coherent System of Credentialing

1984 . ANA Board of Directors report - Progress Toward a Coordinated System of Credentialing in Nursing

1986 . ANA Board of Directors report - ANA Center for Credentialing Services
. ANA Board of Directors motion to retain the Center for Credentialing Services within the ANA

1988 . ANA Board of Directors report on Long-Range, Strategic and Business Planning for the ANA. Goal III - Develop a Coordinated System of Credentialing for Nursing
. Cabinet on Nursing Practice Report on Establishment of a Coordinated System of Certification for Nursing
. Resolution on Educational Requirements for ANA Certification
. Presentation of the Strategic Plan adopted in 1986

Relation to 1988 ANA Strategic Plan

Relation to newly language goals in the Strategic Plan

Goal: Goal III - Develop a Coordinated System for Credentialing in Nursing

Supporting Goals: Goal III: Develop a Coordinated System for Credentialing in Nursing

1. Reflect the educational structure of nursing in legal credentials for entry into practice.
2. Develop certification through the professional association.
3. Develop a unified accreditation system for nursing education.
4. Develop a unified accreditation system for nursing services.

1988 House of Delegates

Subject of the Proposal: The Congressional Role of ANA for Credentialing in Nursing

Originating Unit: The New Hamp State Nurses Association

Contact Person: Barbara M. Hunton, Registered Nurse, MPA, Executive Director (603-456-4771)

Proposed Testimony or Background: Discussion of all relations to separately incorporate credentialing activities apart from ANA.

Range of Direct Costs: $ 0 - $0.00

3-23-88

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American Nurses' Association, Inc.
2420 Pershing Road, Kansas City, Missouri 64108
(816) 474-5720

TO: Presidents and Executive Directors
State Nurses' Associations

PLEASE REPLY BY MAY 17, 1988

FROM: Margretta Styles, Ed.D., R.N., FAAN
President

Virginia Trotter Betts, J.D., M.S.N., R.N.
Chairperson, Constituent Forum

DATE: April 1, 1988

RE: Review of Statement of Understanding Between ANA and Constituent Member SNAs

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In the Friday mailing of March 4, 1988, a copy of the "Statement of Understanding Between the American Nurses' Association and Constituent Member State Nurses' Associations" was sent to you along with an addendum identifying those services listed in the document that were not funded for 1988. This version of the document incorporated a comment column, for your use in making recommendations, for changes or improvements to the Statement of Understanding for use in the years ahead.

The SNA/ANA Business Arrangements Task Force will meet on Wednesday, May 25, 1988 to review this document and consider recommendations for changes to be made to it. It is very important that your SNA's officers, board of directors, or others review this document and supply any recommendations to Marin Goodier, Coordinator, Office of Constituent Relations at ANA headquarters no later than May 17, 1988. This information will be compiled for the task force's use. Don't miss this opportunity to be heard!

MMS:VTB:hmb

American Nurses' Association, Inc.
2420 Pershing Road, Kansas City, Missouri 64108
(816) 474-5720

TO: ANA Board of Directors, SNA Executives, SNA Presidents, DNA Executives, DNA Presidents, Members of ANA Cabinets, Council Executive Committees, House of Delegates Standing Committees, Committees of Examiners, Board on Accreditation, Regional Accrediting Committees

FROM: Eugene L. Ketchum, Ph.D.
Director, Center for Credentialing Services

RE: **The National Distinguished Service Registry in Nursing** -- incorporating the **National Registry of Certified Nurses in Advanced Practice**

DATE: March 30, 1988

The National Distinguished Service Registry in Nursing -- incorporating the **National Registry of Certified Nurses in Advanced Practice** -- is a new joint publishing effort of the American Nurses' Association and U.S. Publications, Inc.

As a leader in the profession, you are invited to be among the honorable individuals who will be listed in the first edition of this new publication.

The Registry will publicly and nationally acknowledge those American nurses who, through their individual civic and professional contributions, through educational achievements, and through dedicated acts of service and generosity, have contributed to the quality of health care and of life in the communities in which they work and live. The book will be published biennially.

Inclusion in **The National Distinguished Service Registry in Nursing** is open *and free of charge*...to those who meet its eligibility criteria; to be listed in the portion of the book that incorporates the **National Registry of Certified Nurses in Advanced Practice** listees must be certified in advanced practice by one of the cooperating professional nursing organizations.

To be considered for inclusion in **The National Distinguished Service Registry in Nursing**, the applicant must be a registered nurse with three or more years in practice and may be nominated by associates or may self-nominate.

In addition, one or more of the following professional distinctions are required:

- Receipt of service awards, commendations, or honors
- Receipt of grants (private or federal), not to include educational scholarships
- Certification by a professional nursing organization
- Publication (state or national distribution only)

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- Professional presentations made (beyond local in-service or "club" presentations)
- Current licensure as an R.N. with a graduate degree in nursing (e.g. M.N or M.S.), Ed.D., Ph.D., or D.N.Sc.
- Membership in a professional nursing society, such as a constituent state nurses' association of the American Nurses' Association.

To qualify for inclusion in the **National Registry of Certified Nurses in Advanced Practice** portion of the publication, applicants must be currently licensed as a registered nurse, and certified as a nurse specialist or nurse practitioner by one of the following organizations:

- American Association of Nurse Anesthetists Council on Certification of Nurse Anesthetists
- American Association of Nurse Anesthetists Council on Recertification of Nurse Anesthetists
- American College of Nurse-Midwives, Division of Competency Assessment
- American Nurses' Association, Committees of Examiners
- NAACOG Certification Corporation
- National Board of Pediatric Nurse Practitioners and Associates.

National distribution of the Registry will be to business, public and private agencies, libraries, schools of nursing, hospitals, insurance companies, and other professionals in the field. It will serve as a valuable resource to employers, recruiters, historians, and others in the health care professions.

Listees, members of state nurses' associations that are constituents of the American Nurses' Association, and others may purchase copies of the Registry at a special pre-publication price of $50.00 (plus $3.50 postage and handling.) Following publication, cost of the book will be $59.00.

A biographical application/publication order form accompanies this invitation. (If you are certified as a clinical specialist, nurse anesthetist, nurse-midwife, or nurse practitioner, please call (800) 821-5834, 8:30 a.m.-4:30 p.m., weekdays, central time, to request a special biographical application form. In Missouri, call (816) 474-5720.)

We believe that a national record of distinguished nurses has been long overdue; we are pleased at the opportunity to produce such a record in cooperation with U.S. Publications, Inc.

I sincerely hope that you will join your colleagues in listing in this historic publication, and that you will support the association's efforts in initiating this national project. You may even wish to purchase a copy of the publication as a gift to your favorite nursing or public library.

Please note that completed application forms must be returned by May 6, 1988. If you have any questions, please feel free to contact me or Marcia Beard Hurt at (816) 474-5720.

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U.S. Publications

American Nurses' Association

APPLICATION

For Listing in the 1988

"National Distinguished Service Registry in Nursing"

Incorporating

The National Registry of Certified Nurses in Advanced Practice

Application Deadline: May 6, 1988

Place completed application form in envelope

RETURN TO: American Nurses' Association
P.O. Box #38
Dept. #0286
Kansas City, MO 64183-0286

PART I

NAME AND ADDRESS

Type or print clearly your name and address as you would like them to appear in the registry. Use both upper and lower case letters as appropriate. Note that you are asked to list two telephone numbers: one is to be listed in the registry; the other is to be used by registry staff to reach you during working hours should questions arise concerning the information you have provided.

Last First Middle Initial

Preferred mailing address Street Suite/apartment No. (circle one)

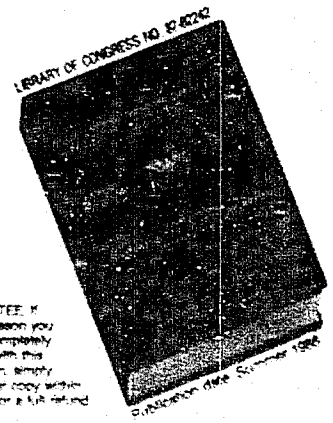
City State Zip Code

Telephone number to be listed _____
Area Code Telephone

Telephone number for staff use
☐ Same as above ☐ Other _____
Area Code Telephone

Social Security Number ___ — ___ — _____

Total number of years as a Registered Nurse _____



GUARANTEE: If for any reason you are not completely satisfied with this publication, simply return your copy within ten days for a full refund.

Honorees Pre-Publication Discount Reservation*

PRE-PUBLICATION PRICE *(Available at this time only)*.... $50.00

*Check or credit card number must accompany reservation.

Quantity _____ TOTAL ....*(Add $3.50 per copy for Postage & Handling)*.... $ _____

☐ Check payable to American Nurses' Association is enclosed.

☐ Charge to ☐ VISA ☐ M.C

Card # _____

Expiration Date _____

Signature _____

* NOTE: If your biography is not accepted for inclusion, you will receive a full refund. *

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PART II

Type or print clearly

EMPLOYMENT

On the lines below identify a maximum of three present and/or past employers relevant to your listing. Specify your job title at time with that employer. **Type or clearly print.** Do not abbreviate your employers name.

Current
Employer ..... Position .....
City, State ..... Dates .....
Employer ..... Position .....
City, State ..... Dates .....
Employer ..... Position .....
City, State ..... Dates .....

EDUCATION

List all post high school degrees or nursing diploma received. List degrees chronologically, starting with the first degree granted (e.g. B.S.N., 1972; M.A., 1980).

Nursing diploma ☐ yes ☐ no Year .....
Degree Initials ..... Year .....
Degree Initials ..... Year .....
Degree Initials ..... Year .....
Degree Initials ..... Year .....

Specialty Preparation (if applicable)

Indicate where you received your specialty education, and the type of program in which you were enrolled (certificate or degree).

☐ Certificate Year of graduation .....

Full name of institution .....

City ..... State .....

☐ Master's or higher degree ..... Degree Initials ..... Year of graduation .....

Full name of institution .....

City ..... State .....

MILITARY SERVICE: (if applicable)

Branch ..... Yrs. of Service ..... Highest Rank .....

PROFESSIONAL MEMBERSHIPS: (including any Offices Held, limit three)

1 .....
2 .....
3 .....

SPECIALTY CERTIFICATION: (if applicable, please list in space below, areas of certification and national nursing organization awarding certification, limit three)

1. Certification Area .....
   Certification Organization .....
2. Certification Area .....
   Certification Organization .....
3. Certification Area .....
   Certification Organization .....

AREAS OF EXPERTISE: (Brief Description, limit three)

1 .....
2 .....
3 .....

Continued on next page

PART II

(Continued)

PROFESSIONAL DISTINCTIONS: (service awards, honors, grants, publications, presentations, etc.)

1 .....
2 .....
3 .....

COMMUNITY ORGANIZATIONS: (Churches, Lodges, Clubs, Charitable Organizations, etc., limit three)

1 .....
2 .....
3 .....

BIRTH PLACE City ..... State ..... Birthdate ..... (Optional)

PARENT(S) Father, First ..... Middle ..... Last .....
Mother, First ..... Maiden ..... Last .....

PARENT(S) Address .....
City ..... State ..... Zip .....

SPOUSE First ..... Middle or Maiden ..... Date Wed ..... (Optional)

CHILDREN (first names only) .....

HOBBIES .....

NOMINATIONS: (Please lend your expertise to the identification of other outstanding nurses in your geographic area by nominating those of your employees, peers or colleagues whom you believe also deserve recognition for their service to the field of Nursing. Use additional sheet if desired.)

Name: Mr. Ms. Dr. .....
Address ..... City ..... State ..... Zip .....

Name: Mr. Ms. Dr. .....
Address ..... City ..... State ..... Zip .....

STATEMENT OF UNDERSTANDING: (All Applicants)

I hereby apply for listing in the "National Distinguished Service Registry in Nursing" to be published in 1988 by U.S. Publications and the American Nurses' Association. I am currently licensed to practice nursing in the United States and/or territories indicated. I understand that, due to space limitations, U.S. Publications and The American Nurses' Association respectfully reserve the right to limit the number of applications accepted. To the best of my knowledge, the information on this application is accurate.

Signature ..... Date .....

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American Nurses' Association, Inc.
2420 Pershing Road, Kansas City, Missouri 64108
(816) 474-5720

TO: Board of Directors
State Nurses' Associations
Presidents
Executive Directors

FROM: Karen S. O'Connor, M.A., R.N.
Director
Division of Nursing Practice and Economics

DATE: April 1, 1988

RE: AMA Report: CC(A-87): Nursing Education and the Supply of Nursing Personnel in the United States

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Attached please find information regarding a report to the Board of Trustees of the American Medical Association regarding a proposed implementation plan for the AMA House of Delegates Report: CC(A-87): Nursing Education and the Supply of Nursing Personnel in the United States.

Some State Nurses' Associations and other elected officials of the Association have become aware of this report and have inquired if there is a national plan to respond. This memorandum is to inform you of ANA's actions to date. It has also come to our attention that the proposed plan has been distributed by the American Association of Colleges of Nursing.

The Executive Committee of the ANA Board of Directors received the report on March 29, 1988. The Executive Committee plans to discuss this report with the AMA Executive Committee during the regularly scheduled joint meeting of ANA and AMA on Monday, April 4, 1988. At this time, a determination can be made regarding AMA's intent to implement this plan. Opposition to AMA's approach of creating registered care technicians as a solution to increase the nurse supply at the bedside in acute and long-term care will be made clear. ANA will focus on all matters related to retention in the health care system.

Please look forward to continued correspondence about this issue. It is ANA's intent to design a plan for action if necessary. Please advise the Kansas City office, Irma Lou Hirsch or myself, of any information that you become aware of related to actions of state medical societies about this matter. Thank you for your attention to this matter.

Enclosures:

- AMA House of Delegates Report CC(A-87): Nursing Education and the Supply of Nursing Personnel in the United States

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. ANA Response: delivered December 4, 198[illegible] by Mary Long--ANA Board member.

. Proposed implementation plan for report [illegible].

KSO:vfb:1:30

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IMPLEMENTATION OF REPORT CC (I-87)

In December 1987, the House of Delegates approved BOT Report CC "Nursing Education and the Supply of Nursing Personnel in the United States." Implementation of the recommendations of Report CC requires 1) cooperation with other organizations concerned with acute and chronic hospital care to develop quality educational programs and methods of accreditation to increase the availability of caregivers at the bedside; 2) supporting hospital based continuing education programs to prepare personnel in critical care units; and 3) supporting all levels of nursing education and efforts to recruit, educate, and retain high quality individuals providing bedside nursing care. This report presents a plan to implement this policy.

Background

Nursing accredits and teaches programs at four levels of preparation, the twelve month licensed practical nurse (LPN), the two year associate degree (AD), the three year diploma (DN), and the four year baccalaureate programs awarding a bachelor of science in nursing (BSN). The LPN and DN programs are described as hospital based, bedside care programs. Clinical nurse specialists and nurse practitioners are usually educated at the masters and doctoral graduate levels. Consistent with the goal of nursing to achieve autonomous professional status, hospital based programs preparing bedside care nurses are being phased out. It is planned to end accreditation of programs preparing LPN and Diploma nurses by 1992 and 1995 respectively. (Report CC (I-87) is attached.)

Cooperation with Concerned Health Care Organizations

Several associations have expressed concerns at the shortage of nurses at the bedside. The American Health Care Association, representing the largest number of long term care facilities in the country has been vocal in ~~opposition to the phasing out~~ of programs for ~~LPN's~~. These nurses are the ~~main source of bedside care~~ in institutions for the chronically ill. The American Hospital Association has expressed public concern and the Federation of American Health Systems considers the problem an impediment to hospital services. Other associations that represent educational organizations such as the American Association of Community Junior Colleges also view the problem as reducing recruitment of students. These associations have resources to facilitate programs of education of bedside personnel. Specialty Medical Associations such as the American College of Surgeons and the American Association of Emergency Room Physicians may also wish to cooperate in plans to increase the pool of trained personnel to give care at the bedside.

The Development of Programs for Bedside Caregivers

The proficiency of personnel to deliver care in institutions may be divided into 1) basic and 2) advanced preparation. Basic bedside care is necessary for all hospitalized patients and includes the

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maintenance of patient wellbeing as well as observations of patient responses to prescriptions that require relatively low levels of technology. This level of education is provided by the current LPN programs. Advanced preparation includes the fundamentals of caring for the sick but adds the knowledge of monitoring highly technical medical procedures, necessary to preserve life. This high technology care is usually delivered in acute care facilities and has been provided in the past, mainly by nurses prepared in diploma programs.

Basic knowledge of how to care for patients at the bedside is required to assure that quality care is implemented with understanding of fundamental human needs. Care requiring less advanced technologic preparation is delivered in facilities for the aged, the mentally ill, the mentally incapacitated, and the chronically disabled. The shortage of personnel in these areas is not new. As the population rapidly ages and medical science prolongs the life of many patients who previously would have died more personnel will be required in long term care. The need for bedside care givers in long term institutions influences and competes with the need in acute care facilities. Availability of nurses and bedside care givers in both settings will have to be addressed, simultaneously, to adequately implement the recommendations of the House of Delegates.

Continuing and formal education programs to prepare bedside care givers must meet several criteria. It is vital that the public be assured of care at the bedside through personnel who have completed accredited programs of education. This will assure the delivery of care at the bedside to the sick and disabled by safe, effective, and qualified persons. It is also important that programs of education are available to supplement programs LPN and diploma programs that are being phased out. Additionally, hospital and agency administrators must be clearly aware of how new personnel fits into the needs of their organizations. To achieve these goals several objectives must be met:

1] The program must prepare bedside care givers to ensure the safe monitoring of ~~medical~~ protocols in acute and long term clinical settings.

2] Adequate ~~numbers~~ of bedside care givers must be prepared in a time period that is compatible with delivery of safe, effective, quality care at the bedside.

3] The ~~title~~ of the new bedside care giver must indicate scope of practice and be flexible enough to attract a broad range of recruits.

4] The program must provide a ~~license~~ to practice at the bedside and qualify for national accreditation.

5] The program must interface with current hospital based nursing programs in such a way that they provide an ~~alternate qualification~~ for which nurses can be eligible if they so desire.

A Basic Program of Education to Prepare Bedside Personnel

Title: Registered Care Technologist (RCT)

The title provides a clear indication of the level of education of the provider; it is technical. It is not associated with nomenclature used by other allied health professions; at the same time, it places the new role at the bedside rather than a managerial role that requires a different kind of educational preparation. The title, "Registered Care Technologist", is flexible enough to be divided into two areas of preparation. The basic, relatively low technology care, is similar to LPN programs. An area of specialization in high technology bedside care through certification retains the title and will be available for current RNs who wish to remain at the bedside.

Scope of Practice:

The scope of practice of Registered Care Technologist (RCT) will be to execute the medical protocols at the bedside with special emphasis on technical skills. The Registered Care Technologist will receive basic courses required to qualify for State licensure and be eligible for advanced certification. ~~A basic RCT~~ is taught "low tech" care and patient maintenance; the ~~advanced RCT~~ has additional training in a "high tech" areas such as intensive care, renal dialysis, or ~~m~~ergency rooms. The RCT will be able to care for the chronically ill and ~~f~~ail elderly and also the less critical patients in acute care settings. The RCT (advanced) will be educated and certified to deliver bedside care in all types of critical care units.

Curriculum

1) Basic Preparation

The curricula will include ~~two phases~~ of preparation. The first phase will prepare students to qualify for the ~~basic license~~ as an RCT; the second phase will prepare and certify the ~~advanced bedside care~~ technologist. ~~Each phase will take 9 months~~ of preparation. The basic curriculum in phase 1 will encompass care for patients that is fundamental to quality bedside care. It includes the monitoring of routine medications, urinary intake and output, care of the mouth and skin, monitoring of vital signs, and the recording of patient observations, using a computer when necessary. The safe and compassionate attention to ~~activities of daily living~~ — bathing, ambulation and nutrition — is included in the duties of the "low tech" patient care technologist (RCT). It is important that the setting for practice ~~does not define~~ the curriculum (e.g. geriatric or psychiatric); the content is basic care of all patients requiring custodial care and/or bedside care in homes, hospitals, and long term care facilities. Theoretical courses include anatomy and physiology, introduction to mathematics to ~~pass medications ordered by physicians~~, developmental psychology and sociology, and the use of computers to retrieve and record physician communications. This curriculum is compatible with the current education for LPNs. During the first three months of the basic program, theory taught in the classroom will exceed clinical experience taught at the bedside.

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2. Advanced Preparation

The curriculum for the RCT (advanced) specializing as a critical care technologist includes rotations through critical care units, the operating room, and post anesthesia room. The courses will include monitoring I/V infusion therapy, hyperalimentation, mechanical respirators, cardiac monitors, central venous pressure, and other medical prescriptions for the critically ill. Non clinical courses will include anatomy and physiology, a composite course of basic science, and other studies designed to enhance understanding and correct interpretation of observations to assure safe care at the bedside. Thereafter clinical teaching on the units of the hospital and in the home will equal or exceed classroom experiences. These courses can also be used for continuing education of qualified personnel. A suggested curriculum for each phase is included in attachments 1 and 2.

Prerequisites

A high school certificate will qualify students to enter the basic program. Graduates from the basic program may practice in low technical areas without an advanced RCT certificate. The advanced program will require a license as an RCT or equivalent experience as indicated, for example, by an LPN or RN license. The licensing examination may be taken by challenge if comparable experience at the bedside can be validated.

Titling and Licensure

The bedside care technologist will be licensed to practice as an RCT through State Statutes. The advanced RCT will receive national certification as a specialist in highly technical care at the bedside. These programs may be offered through Technical and Community Colleges in cooperation with hospitals and agencies throughout the United States.

Accreditation of Programs

Accreditation of education programs for registered care technologists and their certification is available through the Committee on Allied Health Education and Accreditation, (CAHEA). CAHEA utilizes a multiprofessional council to set standards for accreditation of programs.

Supporting the Policies of Nursing to recruit and retain nurses at the bedside.

Organized nursing has adopted several policies in education, administration and legislation to address the need for nurses at the bedside. Methods are being operationalized to assure the easy transition from hospital based programs for LPNs and Diploma nurses into community colleges and baccalaureate programs.

One of the highest priorities of nursing is to increase economic incentives in keeping with the expectations that arise from extended education. New models of hospital administration are being explored to promote managerial autonomy in hospitals, as a method of retaining nurses at the bedside. In addition, nursing has developed many legislative initiatives some of which have already been successful. A Commission on Nursing to develop recommendations for improved recruiting and retention of nurses in health care facilities has been formed by Secretary Bowen. Over 15 million dollars has been appropriated from Congress to fund baccalaureate and graduate education for clinical specialists in nursing. The efforts of the nursing profession to recruit and retain nurses at the bedside are supported by the American Medical Association.

DISCUSSION

The needs of patients to access physician care will be met by producing personnel who are skilled in bedside care for work in institutions and homes. RCT education will supplement and eventually replace those hospital based programs that are being phased out by organized nursing. Licensure at the State level, based on programs accredited by agencies such as CAHEA, will ensure the safe application of care at the bedside. The RCT license can also be acquired by nurses and qualified personnel who can establish sufficient experience at the bedside. This should enable technologists to be educated in the shortest time that is compatible with efficient and effective preparation.

Finally, the integration and effective liaison with nursing can be accomplished through these new bedside care technologists. The RCT is a non-leadership technical role in contrast to professional nursing care that is labeled as autonomous, managerial, and holistic. The program for advanced technologists may be used as continuing education programs for those who are interested in retraining and updating their skills in critical care units. The availability of RCT's will assist business and administration to access interchangable, pools of bedside technologists and nurses for acute and long term facilities.

It is recommended that the Board of Trustees approve the following plan:

- Organize a task force of interested Associations to develop a consensus and coordinate these initiatives to solve the shortage of bedside care personnel in acute and long term care institutions.
- Promote development of educational programs for Registered Care Technologists (RCTs) that can be accredited and certified, perhaps by CAHEA to prepare licensed bedside technologists at basic and advanced levels of preparation.
- Promote development of continuing educational programs for basic RCTs to develop into advanced critical care technologists.
- Coordinate the programs of education for bedside care technologists with other Associations affected by the shortage of personnel at the bedside.

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Attachment #1

CURRICULUM FOR THE BASIC LICENSURE
OF REGISTERED CARE TECHNOLOGISTS

Term 1	Credit hours
Fundamentals of Bedside Care (Care of the skin, sleep, nutrition, etc.)	2
Basic needs for development of functional ability (Ambulation, range of motion, promotion of self care)	2
Anatomy and physiology	2
Developmental psychology (Covering the age range from birth to old age)	2
Mathematics for medications	1
Computer application for recording patient care in hospitals	1
Practicuum (3 hours bedside care per credit hour)	4
Total Credit Hours	14

Term 2	Credit Hours
Pathophysiology	2
Patient Observation, assessment, and recording	2
Administration of medications and other physician prescriptions	2
Identification and recording of patient problems	1
Practicuum (bedside care)	7
Total Credit Hours	14

Term 3	Credit Hours
Psycho/Sociology	2
Pathophysiology	2
Rehabilitation	1
Practicuum (Bedside Care)	9
Total Credit Hours	14

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CURRICULUM FOR CERTIFICATION OF THE
ADVANCED REGISTERED CARE TECHNOLOGISTS

Term 1	Credit Hours
Anatomy and Physiology	2
Pharmacology	2
Computer Engineering for CCU	2
Electrolyte Balance	1
Electrocardiography	1
Practicuum (Adult Critical Care)	6
Total Credit Hours	14

Term 2	Credit Hours
Psycho/Social Aspects of the Critically Ill	2
Pathophysiology	2
Problem Identification and Assessment	1
Recording	1
Practicuum (Pediatric Critical Care)	8
Total Credit Hours	14

Term 3	Credit Hours
Pathophysiology	2
Laboratory Tests	1
Advanced Pharmacology	1
Practicuum in a specialized care unit (dialysis unit, burn unit, emergency care or other)	10
Total Credit Hours	14

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REPORT OF THE BOARD OF TRUSTEES

Report: CC
(I-87)

Subject: Nursing Education and the Supply of Nursing Personnel in the United States

Presented by: Alan R. Nelson, M.D., Chairman,

Referred to: Reference Committee C
(Robert T. Moyers, M.D., Chairman)

At the 1986 Interim Meeting, the House of Delegates adopted Substitute Resolution 88. The resolution called for a report on nursing education and the supply of nursing personnel in the United States.

Background

There are 1.9 million registered nurses (RN) in the United States. In addition there are over 750,000 licensed practical nurses (LPN); therefore it is reasonable to say that the potential workforce of all nurses, RNs and LPNs, numbers about 2.5 million.

About 1.5 million RNs are in the work force either part time or full time; about 68% are employed in hospitals.[1] The remainder are employed in the community, in public and proprietary home health agencies, and in a variety of settings such as insurance agencies and academia. The number of certified nurse practitioners and clinical nurse specialists is difficult to confirm due mainly to problems of definition, but it is estimated that there are at least 100,000 in the United States. In hospitals 71% of the nurse force are technical nurses with associate degree/diploma preparation. LPNs are employed in larger proportions by Veterans Administration hospitals and smaller community hospitals. In nursing homes LPNs outnumber RNs four to one.[2] Only 7.1% of all RNs work in nursing homes.[3]

Past House Action: A-83:96:337; I-82:40-9:324; A-80:105-110; A-70:Report T:328-9; A-68:173-174; A-67:92; I-66:101; I-59:219-220; A-59:32:71-72; A-58:38:51; I-54:80:100; I-53:11:48-50; A-23:25-27; A-22:2:39; A-1869:41-159:174; A-1868:24

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At the present time there are four levels of nursing education, the 12-month licensed practical nurse (LPN), the two (academic) year associate degree Nurse (ADN), the three year hospital-based or diploma nurse (Diploma), and the four-year baccalaureate nurse programs. Four-year collegiate education awards a bachelor of science degree in nursing, the BSN.

Registration to practice nursing (RN), can be obtained through the same board examination taken by the ADN, diploma, and the four-year baccalaureate nurse. License to practice as an LPN is acquired through a special examination. All licensure examinations are produced and monitored through the National Council of State Licensing Boards. All programs in nursing education, including LPN, ADN, Diploma, and BSN are accredited through the National League for Nursing (NLN), which claims educational activities as its professional prerogative.

The American Nurses Association (ANA) certifies about 45% of clinical nurse specialists and nurse practitioners; otherwise ANA is not directly involved with education. The ANA expedites statutory changes in the state nurse practice acts such as those that are currently being promoted to restrict the RN licensure to four-year baccalaureate nurses. To date this change in the nurse practice acts has been vigorously and effectively opposed by practicing nurses in the state legislatures.

Historical Perspectives

Since 1868, the AMA has supported quality education for nurses.[4] A shortage of nurses occurred after the first World War. In 1922 organized medicine urged the involvement of physicians in determining the curriculum for nursing education, accrediting programs, and teaching in schools of nursing. In the same year the AMA formed a Committee on Nursing and Nursing Education,[5] which reported regularly to the House of Delegates until the depression years. In 1923 the Goldmark Report on nursing education,[6] funded by the Rockefeller Foundation, stated that hospital-based Diploma nursing programs did not resemble those in educational institutions. It was noted that the work of student nurses in hospitals was in excess of necessary requirements for education and represented an apprenticeship that defrayed hospital costs. The report suggested that all education for nursing should be in university settings.

In 1933, the AMA cosponsored a joint study of medical and nursing schools with the National League for Nursing Education (NLNE), the American Hospital Association (AHA), and others. Seventy-nine medical schools were reviewed, as well as 2,000 schools of nursing. Although about 40 nursing schools had university affiliations, diploma programs accounted for 98% of all nursing

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schools at this time. The surplus of nurses that occurred in the early 1930s was viewed by the National League for Nursing Education as an opportunity to upgrade nursing educational programs, diminish recruitment, and limit the number of schools of nursing. As a result organized nursing planned to place all programs under nursing direction and to use only graduate nurses, when possible, at the bedside. Notwithstanding, in 1950 75% of all classes in medical surgical nursing, pediatrics, and obstetrics were taught by physicians, and the majority of RNs were still diploma graduates.[7]

After World War II the shortage of medical and nursing personnel was critical. Community colleges emerged to promote easy access to education at low cost. The National League for Nursing Education recommended to the Association of Junior Colleges that a study be made of the feasibility of incorporating nursing education into their programs. In 1952 the two-year, post-high school, associate degree (ADN) programs began. About the same time, 12 month programs that started during World War II for licensed practical nurses were incorporated into some, but not all, junior colleges. ADNs were labeled as "bedside" nurses despite the problem of incorporating practical experiences into the 18-month curriculum.

In June 1953 a committee comprised of the AMA, the NLN, and the AHA, as part of a Commission for Improvement of Care of the Patient, presented an eight-point program[8] on nursing affairs that was approved by the AMA's House of Delegates. The report, besides confirming the post World War shortage of bedside nurses, approved the concept of providing methods for transition between the new and old educational programs in nursing. In 1954, as diploma schools continued to decline, the AMA again expressed its concern for availability of nurses as a medical resource for quality bedside care.[9] In 1958[10] the AMA's House of Delegates urged that operating room experience was considered necessary for nurses in training. In the following year, 1959, the AMA House of Delegates approved Resolution 2, recommending physician participation in state Nursing Licensing Boards.[11] This resolution coincided with the successful initiatives by organized nursing to promote all-nurse licensing boards; however, the participation of physicians and nurses on state advisory committees was encouraged.

In 1965 the American Nurses Association stated that all nursing programs should be within the general education system. Diploma or hospital based programs were considered unproductive to the independence required by any profession to govern its own educational concerns. In 1966 the ANA published a position paper supporting two levels of entry into nursing practice — the technical nurse with an associate degree and the professional nurse with a BSN or four-year degree.[12] Hospital-based programs and LPNs were to be phased out. While it was noted that LPNs made a valuable contribution to care in the absence of sufficient RNs, the

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ANA recommended the systematic replacement of LPN and Diploma programs with associate degree education.

At first the associate degree was viewed as an interim step to the baccalaureate program. Towards the end of the 1970s it became apparent that only 3% of graduates from ADN programs and less than 10% of diploma graduates continued their formal education to BSN status. Still, priorities for federal funding of nursing education were to be given to baccalaureate programs and graduate education of nurse specialists. The National League for Nursing expressed concern that the impact of this policy would diminish recruitment into all nursing programs of education and, for a time, supported four levels of education in response to the pressure from their constituencies. NLN reversed this position later and now supports two levels of entry into practice, the technical ADN and the BSN professional nurse; but discontent continues in the ranks to the present day.

The American Medical Association and the American Hospital Association viewed hospital-based nursing school programs as truly educational in character. Nonetheless AMA actions during the late 1960s reaffirmed support for nursing programs at all levels, including higher education for leaders and teachers in nursing.[13-15] There was special emphasis on the need to prepare bedside nurses, including LPNs, and the AMA supported improving salaries for RNs.

In the spring of 1970 the National League for Nursing contacted the AMA at the request of the Council of Diploma Programs, a division of the League. AMA invited NLN and ANA to form an interorganizational committee to explore relationships between medicine and nursing. This committee was the precursor to the National Joint Practice Commission formed between AMA and ANA that was funded through the W. K. Kellogg Foundation and both associations.[16] One of the first discussions of the committee addressed the AMA Board of Trustees Report F (A-70) on "Medicine and Nursing in the 1970s."[17] This report called for constructive physician collaboration with nursing and supported the concept of the physician led team. The report also recognized the need to expand the role of the nurse into clinical specialization. The report was considered by some nursing leaders to show lack of communication with medicine about the independence of nursing as a profession.[18]

In July 1980 in response to Substitute Resolution 78 (A-79) a report on nursing education reaffirmed AMA's policy to support all levels of nursing education.[19] The report quoted an NLN survey[20] (1979) showing that 75% of all practicing RNs had initially graduated from hospital-based Diploma programs; it was this pool of nurses that was most likely to practice in physicians'

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offices. At that time recruitment into all nursing programs had declined 2% and a shortage of nurses giving direct patient care was recognized by organized medicine as urgent. It was estimated in 1978 that 10,000 nurses were titled practitioners, and a further 15,000 were called clinical nurse specialists. Concern was expressed by the AMA that diploma education was being discontinued before an adequate supply of RNs had been secured to meet the needs of hospitalized patients. As a consequence, Resolution 10 (A-81) was adopted by AMA's House calling for the education of medical-surgical nurses devoted to direct patient care.[21]

In 1981 the National Commission on Nursing's (NCN) was convened. The NCN was an independent, multidisciplinary commission funded by the American Hospital Association. It met just after the Institute of Medicine (IOM) began its study of the need for federal funding for nursing education and was charged with developing action plans for the future of nursing. The NCN recommendations were reviewed by the AMA's House in 1982.[22] The NCN supported increased mobility through linkage between the educational programs in nursing, because this goal had not been perceived as effective in the past.[23] The commission also recommended that shrinking private and federal funds should be allocated to ensure adequate numbers of nurses in BSN and graduate programs. Since then, the AMA House of Delegates has maintained its policy of support for all levels of nursing education.

Other Facts on Nursing Education

There is some evidence that increasing the level of education of nurses provides options that remove them from the bedside.[24,25] The preparation of bedside nurses was not the original purpose of baccalaureate education. Originally, advanced education for nurses was intended to promote leaders, managers, and public health nurses for community services. As patient services in hospitals have become more complex and highly technical, the clinical nurse specialist role with a masters degree has been developed to fill the need for complex clinical care at the bedside. Nursing faculty are increasingly working in practice settings to prepare clinically oriented nurses.

New BSN and ADN graduates usually require some hospital in-service education for bedside responsibilities before entering practice. Approximately 50% of all BSN educational programs do not require experience in critical care units and few, if any, require operating room experience. BSN programs accentuate health maintenance, wellness, and leadership skills as well as traditional nursing skills. Clinical nurse specialists require a master's degree for certification in their area. Nurse practitioner status does not require the BSN in many states.

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Nursing Personnel

The numbers of available nurses to meet the demands for nursing services vary in cycles; the demand for nurses increases in times of war and decreases in times of depression and recession. In the period of retrenchment in the late 1970s, a controversy arose regarding the need for further substantial federal funds to assure an adequate supply of nurses. The Institute of Medicine (IOM) published a report on Nursing and Nursing Education in 1983[26] in response to a congressional mandate.[27] The report stated that for 18 years (since 1965) $1.6 billion was appropriated under the Nurse Training Act programs, established for the purpose of improving the quality and distribution of nursing personnel. There was expressed public need for more "generalist" or "bedside" nurses. No further federal support was suggested to increase the overall supply of nurses; however, it was recommended that funds to alleviate specific kinds of nursing shortages and maldistributions to medically underserved populations and to the elderly should be made through public and private sources. The report recognized that estimates of future need varied with methods of measurement and recommended that market forces control the types of nurses required for each setting. According to the IOM report, two factors had made allocation of resources for levels of nursing education difficult: 1) the lack of evidence of the effects on performance of different types of nursing education, and 2) the lack of definition of the scope of practice for different programs of nursing education. These omissions made it difficult to identify the demand for nurses with different competencies. The National Commission on Nursing, studying the same questions, published similar but more global recommendations shortly after the IOM report; these recommendations are now being implemented through the National Commission on Nursing Implementation Project (NCNIP). At this time NCNIP supports two levels of nursing education and the exclusive funding of baccalaureate programs and higher education for clinical nurse specialists/nurse practitioners.

In 1986 the Division of Nursing at the National Institute of Health reported that, on the whole, there was a balance between the demand and supply of nurses, and this situation was expected to extend into the 1990s. The nursing profession, alarmed at the decrease in enrollments in all nursing education programs, predicted a future shortage and questioned the Division of Nursing report. Almost simultaneously it had become apparent to physicians that a shortage of bedside nurses was causing the closure of critical care units and medical surgical beds in many areas of the country. Vacancies in hospitals were documented by surveys conducted by the American Hospital Association. Only 17.6% of hospital surveys reported having no RN vacancies in 1986-1987.[28]

Many reasons for the present shortage of nursing personnel at

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the bedside have been advanced. Lack of incentives for nurses to remain in hospital or to be recruited into the nursing profession are often cited as reasons for the shortage. A repeated theme is the compressed range of salaries for nurses. The beginning salaries in hospitals are accepted as reasonable, an average of $20,000 per year; but for hospital nurses, including head nurses, even after years of service, the salary is compressed below $40,000. This issue is complicated by the fact that 1) nursing care costs are the largest ongoing item in hospital budgets, 2) there is little salary differential for technical and professional nurses as the BSN nurse seldom gets much more for clinical hospital practice than ADN and Diploma RNs, and 3) health care costs must be competitive in the present health system. A salient reason is that the prospective payment system has curtailed the length of stay in hospital and increased the number of acutely ill patients. This has precipitated the need for qualified nurses at the bedside.

There are deterrents to nursing recruitment. The American Health Care Association expressed its concern that limiting entry to two levels of nursing education leading to nursing practice may adversely influence entry into the field. Another deterrent to nursing recruitment is the lack of upward mobility in nursing. The 1983 Institute of Medicine study of nursing education, in order to encourage interest in entering the field of nursing, strongly recommended the "ladder" concept, the linkage and easy transition from beginning nursing programs to higher education. The concept has encountered many barriers to effective implementation.

Other reasons presented for the shortage of bedside, medical-surgical nurses are as follows: lack of status of the nursing profession; lack of incentives from within and without nursing to remain at the bedside; and lack of ability of nursing to compete for baccalaureate students with programs for other professions, notably law and medicine, especially in an era of reduced numbers of high school graduates eligible for college. The decline in enrollment in all nursing programs has been seen in BSN programs disproportionately. At least two baccalaureate nursing programs have closed in the past year. The future portends a continuing decline in the supply of nursing personnel should these trends continue.

Summary

For over 140 years organized medicine has been concerned with nursing education and its influence on the availability of nurses to monitor medical procedures at the bedside. Up to the second World War, education for nursing care as a medical resource for care of the sick and maintenance of the well was influenced strongly by physicians. Throughout this century nursing has diligently pursued professional status and the independent control of nursing education

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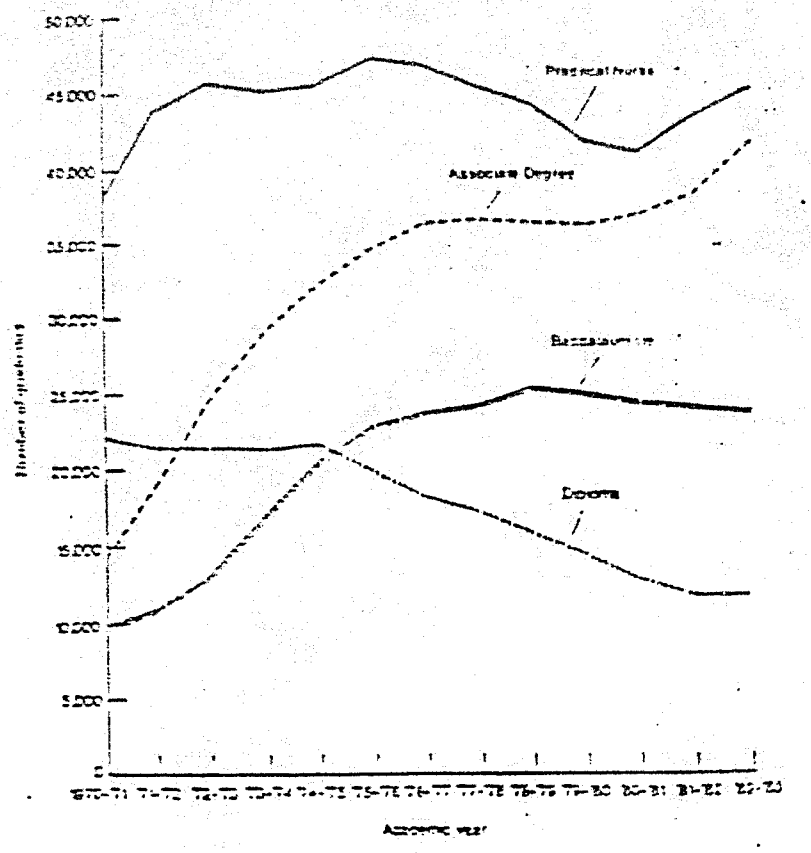
that is a prerequisite to professionalism. The AMA continues to support higher education for nurses and all levels of preparation. The Association's concern is that there will be adequate numbers of well-prepared nurses and caregivers available at the bedside to provide patient care. Nurses are a critical medical resource in delivery of modern care.

The decline of hospital-based programs is evident in the number of yearly graduates. It was estimated in 1984 that 14% of RNs graduated with diplomas, 52% held associate degrees and 33% of all RNs held bachelors of science degrees in nursing. (See Figure #1)[29]

Figure 1 - Graduations from Basic Nursing Education Programs Preparing for Licensure, United States, Academic Years, 1970-71 Through 1982-83



#29 Source: National League for Nursing, Division of Public Policy and Research, Nursing Student Census, 1984: NLN Nursing Data Book, 1983-84, and National League for Nursing, State-Approved Schools of Nursing - LPN/LVN, 1984.

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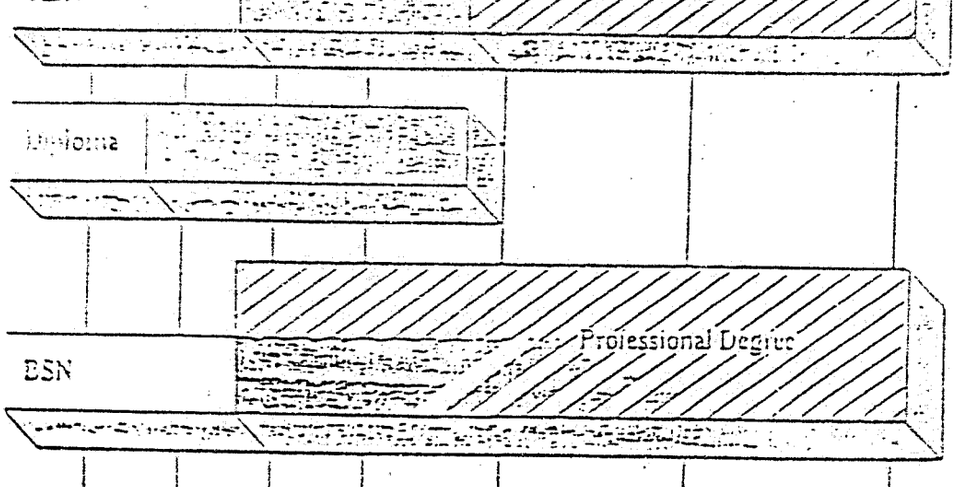
Two-thirds of all nurses in the United States are prepared as technical nurses and one third as professional nurses with BSNs. By the year 2000, it is planned that all education in nursing will be associate degree, (technical) or baccalaureate (professional) programs. (See Figure #2).[30]

Figure 2. Nursing Programs Now and In the Future



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Recommendations:

The Board of Trustees recommends that the American Medical Association:

1. Support all levels of nursing education, at least until the crisis in the supply of bedside care personnel is resolved.

2. Support government and private initiatives that would facilitate the recruitment and education of nurses to provide care at the bedside.

3. Support economic and professional incentives to attract and retain high quality individuals to provide bedside nursing care.

4. Support hospital-based continuing education programs to promote the education of caregivers who assist in the implementation of medical procedures in critical care units, the operating and emergency rooms, and medical-surgical care.

5. Cooperate with other organizations concerned with acute and chronic hospital care to develop quality educational programs and methods of accreditation of programs to increase the availability of caregivers at the bedside and to meet the medical needs of the public.

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TO: Robert T. Moyers, M.D.
Chairman, AMA Reference Committee C

FROM: Mary N. Long, R.N.
Member, Board of Directors

DATE: December 7, 1987

RE: Report CC of the Board of Trustees:
Nursing Education and the Supply of Nursing Personnel in the United States

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The American Nurses' Association is pleased that the American Medical Association has provided this opportunity to respond to the Report of the AMA Board of Trustees on "Nursing Education and the Supply of Nursing Personnel in the United States."

The American Nurses' Association (ANA) agrees with the American Medical Association (AMA) that a shortage of registered professional nurses affects the delivery of safe and effective health care services in our nation. ANA also agrees that the need for qualified professional nurses is increasing. This is due in part to today's complex medical therapies, technologies and to the expanding health care needs of the country's aging population. It is clear that in order for this country to maintain its excellent health care system a supply of professional nurses who can provide direct patient care must be assured. The reasons for the present shortage include: 1) lack of long-term financial rewards in nursing careers due to salary compression; 2) the absence of role responsibilities commensurate with those for which professional nurses have been educated; and 3) the increased expectations for nurses to provide, without the necessary resources or support, more services for patients.

In addition to these current conditions there are powerful forces which indicate that the problem with the supply of nurses will persist for years to come. These include: 1) expanding opportunities for women to enter other professions such as law, medicine, engineering and business; 2) an overall decrease in the number of young people entering the nation's colleges and universities; 3) continuing pressures for health care cost containment that do not recognize nursing's unique contributions; and 4) increased demand for nursing care because of demographic trends in our society. These factors suggest that the current nursing shortage will persist into the future.

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ANA can not agree with all of the recommendations of the AMA Board of Trustees. ANA would invite AMA to further examine the facts and the dynamics that are contributing to the nursing shortage and possibilities for a long term solution.

AMA's first recommendation proposes to support "all levels" of nursing education until the current supply crisis for nursing is resolved. ANA believes that a more appropriate recommendation is: To support nursing education primarily at the baccalaureate level. The rationale for this recommendation is based on three primary considerations. First, increasing acuity among hospitalized patients is increasing the demand for better-prepared nurses with abilities to cope with more complex responsibilities and to exercise greater judgment regarding patient management. Second, the Fifth Report to the President and Congress on the Status of Health Personnel in the U.S. (1986) projects that the imbalance between the available supply and required number of baccalaureate nurses will be severe by the year 2000. Some 510,000 available, with approximately 1,080,000 required by the year 2000, a shortage of more than 500 ,000 BSN's. Third, supporting all levels of nursing education continues to delay and frustrate efforts to provide economic and professional incentives that will attract and retain high quality individuals. Such delays perpetuate multiple and confusing avenues for entry into nursing practice. Baccalaureate preparation will enable professional nursing to be more competitive with other professions.

The second and third recommendations would provide support for incentives aimed at recruiting and retaining professional nurses to deliver direct patient care. In these recommendations an assumption is made that the shortages exist at "the bedside" in hospitals. Available data about the current nursing shortage is almost exclusively limited to hospitals. However, continuing extensive recruitment efforts in other areas of nursing practice indicate that they are experiencing significant supply problems as well. Such areas include nursing homes, home health and other long term care facilities.

The fourth recommendation supports hospital based continuing education programs that would educate "caregivers" to assist with medical procedures in specific limited areas. ANA is concerned that this recommendation lacks clarity. Additional information is necessary about the purpose, nature and content of these proposed continuing education programs and the intended audiences. In addition, ANA is concerned that a focus on continuing education in a few specific areas will not meet today's need or tomorrow's demand for professional nurses.

ANA opposes recommendation number five. Although the intent is not entirely clear, it appears to sanction the development of programs on an institutional or organizational basis ostensibly to increase the availability of "caregivers." Such programs could jeopardize individual and professional responsibility and place the authority for licensing and credentialing with the health care facility. Health care institutions are responsible for facilitating the delivery of services, not for determing legally sanctioned professional roles and functions nor the kind and degree of educational preparation.

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Successful strategies for retaining professional nurses will have an immediate impact on the current shortage. Successful strategies have been well documented and proven effective in a number of facilities. These strategies include 1) the provision of a practice environment within which nurses have appropriate control over the nursing plan of care, and in which the knowledge and skills of both nurses and physicians is brought to bear on decisions related to the quality of patient care; 2) a supportive administrative structure with sufficient professional nurse staffing and resources; 3) a salary structure that rewards the nurse for level of responsibility, preparation, experience and performance; and 4) opportunities for professional development.

Successful recruitment strategies coupled with genuine retention efforts are required for long-term stabilization of the supply of professional nurses. Nursing is competing with law, engineering, business and medicine for the best and brightest young people. Economic incentives and career growth are important components of a career choice today. Salary compression and the public perception of nursing must be addressed to attract individuals into the profession.

ANA, through its 53 constituent state nurses' associations and other national nursing organizations, has been actively engaged in efforts designed to recruit qualified individuals and retain professional nurses. ANA assists the state nurses' associations as they respond to the problems created by a shortage of nurses in their states. At the federal level, ANA has supported legislation designed to provide financial incentives for people to enter schools of nursing and develop a plan which would ensure a continual supply of professional nurses.

In conclusion, ANA believes that solutions to the shortage must address immediate needs and the needs of the year 2000. Such solutions require that:

- Nursing education be supported primarily at the baccalaureate level through federal funding and other programs.
- Professional nurses are appropriately compensated with salaries and benefits commensurate with other professionals.
- Professional nursing practice provides role responsibilities consistent with those for which nurses have been educated.

DLM:ds

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JCH

Oklahoma Nurses Association

6414 N. Santa Fe, Suite A, Oklahoma City, Oklahoma 73116 (405) 840-3476

March 25, 1988

Juanita K. Hunter, EdD, RN
President
New York State Nurses Association
2113 Western Ave.
Guilderland, NY 12084

Dear Juanita:

The Oklahoma Nurses Association Board of Directors is suggesting Claudine F. Dickey for appointment to the ANA Cabinet on Nursing Education for the 1988-1990 term. She will complete her term as ONA president in October 1988.

Claudine will be an effective member of the Cabinet, if appointed. Three particular strengths she offers for this position include: 1) two terms as ONA president (1981-1982 and 1986-1988); 2) experience in a baccalaureate program in a large state supported university and a private liberal arts university; and 3) experience in a hospital education department with emphasis on recruitment and retention strategies.

The Board of Directors requests that the New York State Nurses Association endorse ONA's suggested appointment of Claudine to the Cabinet on Nursing Education. Information about Claudine and the form for your endorsement is enclosed.

We appreciate your support of Claudine for this appointment. Please call me if you have any questions regarding this request.

Sincerely,

Frances

Frances I. Waddle, RN
Executive Director

FIW:jw

Enclosures

ATTACHMENT

AMERICAN NURSES' ASSOCIATION

Board of Directors

Committee on Committees

Suggestion for Consideration in Making ANA Appointments

Name Claudine F. Dickey

Address 13808 N. E. 9th

Choctaw, OK 73020

Appointment for which individual is suggested Cabinet on Nursing Education

Biographical data form attached Yes

New York State Nurses Association
Submitted by

Title

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ATTACHMENT 3 **FORM B**

To SNAs
Return signed consent forms to Governance Support Services, ANA.
Attention: Karen A. Kathley

AMERICAN NURSES' ASSOCIATION
BIOGRAPHICAL FORM TO BE COMPLETED BY SNA MEMBER
NO NOMINEE IS CONSIDERED WITHOUT HAVING SUBMITTED THIS FORM

Instructions: Complete form IN FULL regardless of whether you attach a resume, curriculum vitae, or other information. State information clearly and succinctly. Please Type. DO NOT USE ABBREVIATIONS. Data on this form will be used by Nominating Committee. All personal information is CONFIDENTIAL.

Form of Address: ☒ Ms. ☐ Miss ☐ Mrs. ☐ Mr. ☐ Dr. ☐ Other ____

Claudine E. Dickey
Name (Will be used on official documents as printed above)

[redacted]
Home Street Address

Shawnee, OK 74801
City *State* *Zip Code*

[redacted]
Area Code *Home Telephone Number*

Oklahoma Baptist University
Business Address — Name of Organization

500 W. University
Street Address

Shawnee, OK 74801
City *State* *Zip Code*

405/275-2850 x2081
Area Code *Business Telephone Number*

Party Affiliation: Democrat

Current Membership in Oklahoma
State Nurses Association

Preferred Mailing Address: ☒ Home ☐ Business

SNA Membership Number 443300203

Race: Ethnic Group: ☒ White ☐ Black/Negro ☐ Hispanic ☐ American Indian ☐ Japanese ☐ Chinese ☐ Filipino ☐ Hawaiian ☐ Korean ☐ Other ____

EDUCATION (List in descending order of highest degree earned.)

Degree/ Diploma	Area of Study	Year Obtained	School
Adv/PhD	Public Health		University of Oklahoma
BS	Nursing	1967	University of Oklahoma
~~Dipl~~	~~Guidance~~	~~1960~~	~~Central State University~~
BS	Nursing	1960	Oklahoma Baptist University

Other Academic Achievements and Honors (continuing education and certification)

None

Present Position

Oklahoma Baptist University — Dean, School of Nursing
Employing Agency — *Position Title*

Oklahoma — Indefinite — Shawnee
State — *Dates* — *City*

Description of present position to include major clinical, teaching, or practice area; field/place of employment and responsibilities

Present position is primarily administrative with some teaching (3-4 credit hours). Role is to provide leadership for the School of Nursing and represent the nursing program to interface with other administrative units. Clinical area is psych-mental health.

Of the stated criteria, which category do you best meet

A. Demonstrated expertise in the field of nursing education.

B. Knowledge about the social, economic, and political changes that influence society's demand for nursing services and the implications of these changes for nursing resources.

Other Significant Positions Held and Dates (Most recent first)

Position	Employing Agency	Dates
Consultant for Nursing Career Development	Presbyterian Hospital, Okla. City	1980-82
Associate Profession of Nursing	University of Oklahoma	1976-80

Please give examples of opportunity to demonstrate leadership in employment setting:

--Serve as Dean of School of Nursing

--Serve as administrative representative to the university's Faculty Development Committee

OFFICES/APPOINTMENTS/ACTIVITIES IN ANA

(Under each level of the organizational list only THREE offices/appointments/activities. Give COMPLETE NAMES, including DATES)

PRESENT — NATIONAL ANA Office/Appointment/Activity	Dates
(1) None	
(2)	
(3)	

PAST — NATIONAL ANA Office/Appointment/Activity	Dates
(1) None	
(2)	
(3)	

PRESENT — STATE NURSES ASSOCIATION Office/Appointment/Activity	Dates
(1) President	1986-88
(2)	
(3)	

PAST — STATE NURSES ASSOCIATION Office/Appointment/Activity	Dates
(1) 1st Vice President	1982-84
(2) President	1981-82
(3) Secretary	1977-79

PRESENT — DISTRICT OR REGIONAL NURSES ASSOCIATION Office/Appointment/Activity	Dates
(1) None	
(2)	
(3)	

PAST — DISTRICT OR REGIONAL NURSES ASSOCIATION Office/Appointment/Activity	Dates
(1) Director-at-large	1974-80
(2)	
(3)	

Other kinds of leadership activities ON BEHALF OF THE ORGANIZATION (such as representation in international, governmental or community affairs)

Representative to Physican Manpower Training Commission Nursing Scholarship Advisory Comm.
Member, Advisory Council of the Oklahoma Board of Nurse Registration and Nursing Educatio
Representative to Advisory Committee of Oklahoma Department of Human Services

Do you hold membership on a board of directors or other governing body of any other national organization? ☐ Yes ☒ No

Name of Organization — *Offices*

Contributions to a field of nursing.

Reason why you should be considered for this apointment/election

I would bring 20 years of experience in nursing education. I've worked for both a large baccalaureate state supported program as well as in a private liberal arts. In addition, I have had experience in nursing education in a community college.

Involvement in community, and/or state, and/or national planning for health care and related concerns such as planning or advisory committee—health resources committee, citizens planning group, allied health organizations, official health agency

Activities with other associations, such as nursing specialty organizations American Public Health Association, American Heart Association, National Association, National League for Nursing, etc.

1st Vice President, Oklahoma League for Nursing (current)
Chair, Committee on Nominations, Beta Beta Chapter of Sigma Theta Tau (1984-85)
Chair, Eligibility Committee, Beta Beta Chapter of Sigma Theta Tau (1985-86)

3/16/88 — Claudine E. Dickey
Date — *Signature*

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RETURN TO: KAREN A. KEITHLEY
Governance Support Service
American Nurses' Associati
2420 Pershing Road
Kansas City, Missouri 64108

DEPARTMENT

ANA CONSENT FORM AND DATA SHEET

I DO X DO NOT ___ CONSENT TO SERVE AS A MEMBER OF Cabinet on Nursing Education
(Name of Organizational Unit)

NAME _____ HOME TEL. 405/360-2410
(as you wish it to appear in ANA records) (Area Code) (Number)

DEGREES EARNED _____

OTHER CREDENTIALS (e.g. R.N.C. F.A.A.N. etc.) _____

HOME ADDRESS _____

Choctaw OK 73020
(City) (State) (Zip Code)

NAME OF EMPLOYER _____ TITLE Dean

INSTITUTION/ORGANIZATION School of Nursing

ADDRESS _____ BUSINESS TELEPHONE 405/275-2850 X2081
(Area Code) (Number)

Shawnee Oklahoma 74801
(City) (State) (Zip Code)

I DO ___ DO NOT X WISH TO HAVE A LETTER SENT TO MY EMPLOYER AS SHOWN (over). NOTE: If you wish to have a letter sent, please specify the recipient's name and position title and be sure that the recipient's address is complete.

I PREFER TO HAVE ANA MAIL SENT TO: ☒ HOME ADDRESS ☐ BUSINESS ADDRESS

_____ 3/10/88
(Signature) (Date)

.....

FOR TRAVEL INSURANCE PURPOSES:

NAME OF BENEFICIARY _____ RELATIONSHIP Spouse

ADDRESS _____

Choctaw Oklahoma 73020
(City) (State) (Zip Code)

TELEPHONE NUMBER(S): _____
(Area Code) (Number)

Jun. 1982

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THE NEW YORK STATE NURSES ASSOCIATION

1988

ASSEMBLY HIGHER EDUCATION COMMITTEE **ENTRY INTO PRACTICE**

NAME	LEG DIST.	COUNTIES	NYSNA DIST.
CHAIR, EDWARD SULLIVAN(D)	69	New York	13
Frank Barbaro (D)	47	Kings	14
I. William Bianchi, Jr.(D)	3	Suffolk	14
Samuel Colman (D)	93	Rockland	17
Pinny Cooke (R)	132	Monroe	2
Geraldine Daniels (D)	70	New York	13
Donald Davidsen (R)	127	Yates, Steuben	2,3
Thomas DiNapoli (D)	16	Nassau	14
Robert Gaffney (R)	4	Suffolk	14
Roger L. Green (D)	57	Kings	14
R. Stephen Hawley (R)	137	Genesee, Orleans, Monroe	2
Maurice D. Hinchey (D)	101	Ulster	11
Cynthia Jenkins (D)	29	Queens	14
Helen M. Marshall (D)	35	Queens	14
H. Sam MacNeil-Ranking (R)	125	Tompkins, Tioga	3,5
John B. Murtaugh (D)	72	New York	13
Clarence Norman (D)	43	Kings	14
Audrey Pheffer (D)	23	Queens	14
Charles O'Shea (R)	19	Nassau	14
Jose E. Serrano (D)	73	Bronx	13
John B. Sheffer, II (R)	142	Erie	1
Helene E. Weinstein (D)	41	Kings	14

1 VACANCY

cl
11/87

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"ENTRY INTO PRACTICE"

SAMPLE LETTERS

Please alter words or sentences so that the letters do not sound all alike.

Assemblyman _____
New York State Assembly
Albany, NY 12248

Dear Assemblyman _____:

I urge your support of the Entry Into Practice legislation which will standardize the educational preparation for the professional nurse and the licensed practical nurse.

The lack of a standardized education for nurses results in inadequate preparation for many nurses in today's world of scientific and technological advances. It also denies many nurses equal access to career mobility and advancement. This situation is a major reason young people are not choosing nursing as a career.

Please help standardize nursing education so that nurses can compeat in today's society, provide improved care and that recruitment and retention of nurses will be enhanced. I **strongly** urge your support of the Entry Into Practice legislation.

Sincerely,

/cl
**/87

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SENATE EDUCATION COMMITTEE

NAME	LEG DIST.
CHAIRMAN - JAMES DONOVAN (R)	47
Howard E. Babbush-Ranking (D)	17
John B. Daly (R)	61
Roy M. Goodman (R)	26
Kenneth P. LaValle (R)	1
Eugene Levy (R)	38
Norman J. Levy (R)	8
Tarky J. Lombardi (R)	49
Suzi Oppenheimer (D)	36
John D. Perry (D)	54
Jess J. Present (R)	56
Israel Ruiz, Jr. (D)	32
Martin M. Solomon (D)	19
William T. Stachowski (D)	57
Guy Velella (R)	34

ENTRY INTO PRACTICE

COUNTIES	NYSNA DIST.
Lewis, Oneida, Herkimer	6,7
Kings	14
Niagara, Orleans, Erie	1
New York	13
Suffolk	14
Rockland, Orange	17,18
Nassau	14
Onondaga	4
Westchester	16
Monroe	2
Chautauqua, Cattaraugus, Allegany	1 2
Bronx	13
Kings	14
Erie	1
Bronx, Westchester	13,16

/cl
11/87

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"ENTRY INTO PRACTICE"

SAMPLE LETTER

Please alter words or sentences so that the letters do not sound all alike.

Senator _____
Legislative Office Building
Albany, NY 12247

Dear Senator _____:

I strongly support the Entry Into Practice bill and urge you to vote yes in the Education Committee. Until all nursing has a professional education base and is viewed as equal to other professions, we will continue to face nursing shortages because people will select other careers. The grandfather clause will protect those licensed but without the higher education. Standardization and elevation of nursing education is absolutely necessary to ensure the availability of professional nursing to the public.

I urge you to move on this bill.

Sincerely,

/cl
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American Nurses' Association, Inc.
2420 Pershing Road, Kansas City, Missouri 64108
(816) 474-5720

TO: SNA Presidents and Executive Directors
Standing Committees of the ANA House of Delegates
ANA Cabinets
ANA Council Executive Committees

FROM: Margretta M. Styles
President and Chair
ANA Commission on Organizational Assessment and Renewal

DATE: February 18, 1988

RE: Progress Report: Work of the ANA Commission on Organizational Assessment and Renewal

---

As you know, the ANA Board of Directors has approved and I have appointed an ANA Commission on Organizational Assessment and Renewal (COAR).

The Commission is charged to:

- Identify health trends, professional issues and proposals relative to the mission, membership structure and functions of ANA through a variety of means, including consultation with SNAs and other units within ANA, representatives of other elements of organized nursing, and experts in organizational development, corporate structure and marketing, and in the health field.

- Make recommendations for the mission, membership, structure, and functions of the ANA in consideration of the analysis of these findings.

- Devise and implement a process for consensus building within ANA and, as appropriate, with other segments of organized nursing relative to these recommendations.

- Prepare and present an interim report to the ANA House of Delegates in 1988 and to external bodies as appropriate.

- Bring recommendations for change to the 1989 House of Delegates.

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Because of time and resource constraints, the Commission will not collect primary data, but will build on existing internal studies of the ANA and/or other available resource documents.

The ANA Commission will involve four levels of participation. The Commission itself will be composed of 1) a steering committee and 2) an advisory panel. (A roster of steering committee members and advisory panelists is attached.) A consensus building network 3) will encompass SNA's, internal ANA structural units and other organizations, as appropriate. Finally, consultants 4) will be used as the steering committee has need for outside resources.

The steering committee and advisory panel will meet prior to the 1988 House of Delegates to achieve consensus on the current situation, problems and issues confronting the American Nurses' Association and on broad membership and structural options to address these matters. An educational presentation on the present situation and future options will be prepared for the 1988 ANA House of Delegates. The presentation will be shared with the Constituent Forum and through a special forum to be held prior to the House on June 10, 1988.

In the four months following the 1988 House of Delegates, consensus building on issues and solutions will proceed through the convening of special workshops and/or the use of regularly scheduled meetings. Thus, I'm asking that time be set aside at the time of the fall meetings of the SNA regional groups for discussion of the issues and options and urging SNAs to include time during their 1988 conventions for discussion of these matters as well.

Feedback mechanisms will be established to facilitate the input of SNAs and ANA's organizational units during the summer and fall of 1988. Feedback and consensus building will be the basis for the redefinition of the issues and options. The final Commission report and recommendations for implementation of those recommendations in the form of amendments to ANA bylaws will be issued in January, 1989. Ongoing feedback and consensus building will continue throughout the spring. The ANA House of Delegates will act on the Commissions report and related bylaws provisions in June, 1989.

I believe we are off to a good start to strengthen the American Nurses' Association on behalf of its members, the nursing profession and the American people and I look forward to your participation in this process.

MMS:dmb.029
2/18/88

cc: ANA Board of Directors
ANA Commission on Organizational Assessment and Renewal

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ANA COMMISSION ON
ORGANIZATIONAL ASSESSMENT AND RENEWAL

Steering Committee

Margretta Styles, Ed.D., R.N., F.A.A.N., chairperson
Virginia Trotter-Betts, J.D., M.S.N., R.N.
Juanita Fleming, Ph.D., R.N., F.A.A.N.
Norma Lang, Ph.D., R.N., F.A.A.N.
Cecelia Mulvey, M.S.N., R.N.
Myra Snyder, Ed.D., R.N.

Advisory Panel

Brigadier General Clara Adams-Ender, Ph.D., R.N.
Doris Blaney, Ed.D., R.N., F.A.A.N.
Malinda Carter, B.S.N., R.N.
Barbara Donaho, M.A., R.N., F.A.A.N.
Vernice Ferguson, M.A., R.N., F.A.A.N.
Jeanette Hartshorn, Ph.D., R.N.
Sue Hegyvary, Ph.D., R.N., F.A.A.N.
Pamela Hoskins, Ph.D., R.N.
Ada Jacox, Ph.D., R.N.
Karen Macdonald, M.S., R.N.
Kathleen Montgomery, B.S.N., R.N.
Robert Piemonte, Ed.D., R.N.
Donna Poole, M.S.N., R.N.,C.S.
David Ranck, M.S.Ed., R.N.
Muriel Shore, M.S.N., R.N., C.N.A.
Eleanor White, Ph.D., R.N., C.S.

KS:dg:023

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AGENDA #8(b)

THE NEW YORK STATE NURSES ASSOCIATION

SUMMARY OF COMMENTS AT OPEN FORUM RE FUTURE MEMBERSHIP
Held at the ANA Convention in Louisville, Kentucky

Sponsored by:
Connecticut Nurses Association
New York State Nurses Association
Pennsylvania Nurses Association

Connecticut Nurses Association: Carol Polifroni

CNA supported the recommendation of the ANA Board of Directors to defer action on the membership issue. CNA also supports the concept that the RN of the future will be the key member of the professional association. The CNA Board believes that there is a fundamental inconsistency between the practice of the associate nurse, who will work under the direction and guidance of the professional nurse, and the decision of the ANA House of Delegates that the associate nurse would have full membership status. The associate nurse would then be the peer of the professional nurse in determining scope of practice, professional standards, and the code of ethics.

The decision of the House has already confused Connecticut legislators who are working with the CNA to introduce entry legislation in January, 1989.

CNA has no plans to propose withdrawal from ANA.

Pennsylvania Nurses Association: Beth Cathcart

PNA brought the issue of future membership and possible withdrawal from ANA to its membership out of a belief that the Federation has not been fully implemented. PNA believes that ANA continues to work from a model of national individual membership.

The PNA Board did not see the membership issue as the sole problem and cited other problems, including the absence of an SNA-ANA contract.

PNA's membership will again consider the resolution related to withdrawal at its convention this fall. Members will be asked to evaluate the viability of remaining a constituent member of ANA.

The New York State Nurses Association: Juanita Hunter

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A copy of Dr. Hunter's remarks is attached.

AUDIENCE COMMENT

Theresa Stephany, member of California Nurses Association:

Ms. Stephany was personally devastated by the House decision last summer and has made a strong commitment to work for the reversal of the decision. She sent "letters to editors" of 62 nursing publications, suggesting that nurses who support the professional model run for election as ANA delegates. At least seven of the editors responded that they would not be able to publish the letter because their subscribers included many RNs with associate degrees. Ms. Stephany concluded that these editors did not understand the issue and that this was indicative of the lack of understanding of many nurses, delegates, and Association leaders.

Cynthia Capers, member of Pennsylvania Nurses Association:

Ms. Capers concurred with Ms. Stephany's remarks and stated that it was necessary to ask delegates across the nation to reconsider the decision. Also, Ms. Capers believes that if the membership issue is not satisfactorily resolved, another organization will emerge to represent the interests of only professional nurses.

Roberta Olsen, President of Missouri Nurses Association:

Stated that the membership of Missouri NA supports one organization for all nurses (occupational model), but agrees that the decision to change membership requirements was premature. MNA would be willing to reconsider the issue.

Jo Franklin, President of the North Carolina Nurses Association:

NCNA supported the recommendation to defer decision on membership, but abstained from voting on the bylaws amendments because their membership had not yet taken a position on the issue. In the past year, NCNA did take the issue to their members through the district associations. Informal votes at these meetings indicated that the membership prefers a professional model. Therefore, NCNA would like to have the issue reopened.

Betty Maher, Executive Director of North Dakota Nurses Association

North Dakota members believed the decision last summer to be very premature. In the past year, they have held meetings with LPNs around the state to explore the interest in membership in NDNA. There has been no interest expressed.

Ms. Maher also pointed out that many states do not plan entry

legislation which will result in just two levels of nurses. Since there are likely to be three, or in some states, four levels which will continue to exist, how will the membership eligibility be determined?

Norma Lang, ANA Board of Directors:

Believes that COAR may serve as the vehicle for reopening the issue of membership and encouraged everyone to be an active participant in the process.

Ruth Fitzgerald, member of Mass. NA:
Agreed with the comments of North Dakota NA and stressed that it was going to be extremely confusing to discuss two levels of nursing when, in fact, there would continue to be at least three.

Asked if parallel associations with interlocking boards of directors would be an acceptable organizational structure.

Peggy Mussehl, President of Montana Nurses Association:
Agreed that the confusion over levels of nursing practice would completely confuse the membership issue.

Peggy Greaves, President of South Carolina Nurses Association:
Stated that NYSNA and PNA had accomplished a good objective with their resolutions - forcing ANA to take a serious look at the organizational structure. Asked that the membership issue be down-pedalled because of its divisiveness.

There were several other comments supporting those above.

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PRESIDENT HUNTER'S PRESENTATION

NYSNA/PNA/CNA Open Forum re Membership

In 1986, the ANA House of Delegates directed the Committee on Bylaws to prepare proposed amendments of the ANA bylaws which would permit SNAs to extend membership to the technical nurses of the future. At the same time, the House asked the ANA Board of Directors to conduct an in-depth study of the various alternatives for membership of the technical nurse.

NYSNA delegates at that meeting voted unanimously against the proposal to bring forth bylaws amendments in 1987, believing that the ANA Board study should be completed and distributed to the States with sufficient time for the SNAs to refer the matter to their own voting bodies for their consideration, PRIOR to any action of the ANA House of Delegates.

Following the close of the 1986 House of Delegates, the ANA Board of Directors appointed a task force to conduct the study of membership alternatives. The Task Force was unable to complete its work in the short period of time allotted and therefore recommended that action on the bylaws related to membership be deferred until 1988 in order to permit the Board to complete its study.

The NYSNA Board of Directors reviewed the preliminary report of the ANA Board, which was not available until the second delegate mailing early in May, 1987, and concurred that action on

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the membership issue should be deferred until 1988. The NYSNA Board continued to believe that this was a matter of utmost importance to the future of the organization and that the completed study and proposed bylaw amendments should be available to the SNAs for study and possible SNA voting body consideration before any action of the ANA House of Delegates. The NYSNA Board and Delegates to the 1987 House strongly believed that premature action on the membership issue would result in alienating and dividing our membership at a time when our profession was in great need of cohesive leadership.

NYSNA delegates to the 1987 House were extremely disappointed that the preliminary report of the ANA Board of Directors received no substantive discussion either in Reference Hearing or on the floor of the House. Indeed, it appeared that there would be no consideration of deferring the decision in spite of the strong appeal of several SNAs and the ANA Board. Debate in the House of Delegates was tightly controlled and brought to a close by delegations which believed that no further substantive debate was necessary or desirable.

NYSNA believed that there was significant confusion among some delegates as to the meaning of the vote, especially since some delegates spoke in defense of retaining as members registered nurses who had earned associate degrees. There was, of course, no question before us on the continued membership of those nurses.

Following the close of the House of Delegates, the NYSNA

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Board of Directors reviewed the action of the House and the communications of delegates and members on this matter. The Board recognized that the decision of the House was conclusive and that reconsideration of that decision was unlikely. The proposal to withdraw from constituent membership in the ANA was presented to the NYSNA Voting Body in order for the membership to have an opportunity to determine whether it wished for NYSNA to remain a part of an occupational association.

The Voting Body of NYSNA, with more than 1000 members in attendance, voted nearly unanimously in support of a substitute resolution introduced by the Board of Directors. That resolution states the Association's continued commitment to retaining NYSNA as an association of professional nurses and directs us to pursue all available means to reinstate ANA's original mission and purpose as a national self-governing organization of professional nurses. The resolution also directs that a progress report of our efforts be reported to the 1988 NYSNA Voting Body and that the proposed bylaws amendments and resolution related to withdrawal be resubmitted for further consideration.

The rationale for our members' concerns is as follows: The strength and vitality of the profession of nursing are being drained by a variety of societal forces. It is clearly evident that our practice is being eroded and attacked through powerful interest groups who speak in the name of cost-containment, efficiency, and other apparently worthy objectives. Our declining ability to recruit the best candidates for nursing, the

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closure of prestigious schools of professional nursing, abysmal conditions of practice in our health care institutions, so-called "down-substitution" of numerous occupational groups for professional nursing positions, our inability to achieve enactment of vitally needed legislation are but a few examples of a decaying and destructive environment for the profession and for the public whom we attempt to serve.

In the midst of this discouraging and alarming setting, the organizations and institutions which provide leadership and direction for the profession are often rendered powerless and confused by their inability to achieve consensus internally and among themselves. In well-intentioned efforts to promote consensus and a unified voice for nursing, the professional nursing organization (ANA) has had to compromise, over and over again, on key issues and directions for nursing. Because of these compromises, our organization has been unable to focus its resources and our collective efforts on correcting the conditions which are threatening the continued existence of a profession of nursing and the public's access to qualified nursing services.

The decision of the ANA to diversify its membership and to embrace the "occupational" model will alter the basic nature, mission, and purposes of the only multipurpose state and national organization for professional nurses. By placing ourselves in the position of trying to meet the needs of other than professional nurses, ANA and its member SNAs will always have to

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function in an environment of compromise. ANA and the SNAs will be unable to focus their resources and efforts on clearly establishing the profession of nursing when its standards, code of ethics, its policy positions, and its legislative agenda must be acceptable to licensed practical nurses, associate nurses, or any others who are not professional nurses.

Certain parallels and examples may be helpful. Imagine the law profession admitting paralegal assistants to membership in the American Bar Association, or the medical profession admitting physicians' assistants to the AMA with full voting rights and privileges. Think of the conflicts that are so apparent within the National League for Nursing, an organization which just last month again demonstrated its inability to take a clear stand on the entry into practice issue because of the competing interests within itself. Think also of the situations in which labor unions comprised of diverse groups have attempted to speak for nursing and have necessarily mediated and compromised the standards, concerns, and priorities of the professional nurse members.

Nurses in these and similar situations have repeatedly asserted their conviction that professional nurses must have an organization whose purpose, agenda, functions, and resources are committed to the protection and advancement of professional nurses and the nursing profession. NYSNA believes that ANA and the SNAs are and must continue to be that organization.

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JLH

* Note to resource persons: The following is intended as a guide for group discussion. Please feel free to add your own touches or to respond to specific needs of delegates in your group.

ORIENTATION FOR NEW DELEGATES

June 1, 1988

I. Role of House of Delegates

Refer to ANA Bylaws, Article IV, pages 5-7.

II. Process of conducting business of the House:

A. Parliamentary Procedure

All delegates have been given a guide to parliamentary procedure. It is strongly recommended that each delegate review the guide and bring it to Louisville.

Please review the two sheets in the second delegate packet entitled: Procedure on use of microphones in House of Delegates and Proposed Standing Rules for Conduct of Business for the House of Delegates, 1988.

B. Reports and Proposals

Please discuss items VIII, IX, X, and XI on the proposed Standing Rules for Conduct of Business for the House of Delegates.

Provide an opportunity for any additional discussion and/or questions that Delegates may have about processing of Reports and Proposals.

C. Reference Hearings

Please review the white handout in the first delegate mailing entitles: Policies and Procedures for Submission of Proposals to and Hearing Guidelines for the ANA House of Delegates. Emphasize the Hearing Guidelines for Proposals on page 4 of the handout.

Also, refer to the May 2 letter from Mary Stainton, Chairperson of the Reference Committee re "Action of the ANA

Reference Committee on Reports and Proposals Submitted for the 1988 ANA House of Delegates.

Emphasize that it is important for all delegates to be knowledgeable about the process of the Reference Committee. Tell Delegates that the reports and proposals will be brought before the House <u>in the context of the reports of each reference hearing.</u> Delegates will receive the written report of the Reference Hearing, usually the evening before the session of the House at which the report will be heard. Delegates will be asked to vote on any changes recommended by the Reference Committee and then on the amended document. Remind them that it can be very confusing because they must simultaneously use the original document and the report of the Reference Committee for debate and vote in the House.

III. Role of individual delegates

A. Preparation for meetings: how to synthesize large volume of information.

Caution Delegates to take a few minutes each evening to organize materials for the next session of the House. The process is often so fast paced that Delegates are still trying to find the appropriate pieces of paper while discussion is taking place.

Stress the importance of being in the House a few minutes <u>before</u> the call to order since that is the time when any last minute information will be provided by Delegate Captains.

Add any of your own "tips." Remind them that Convention News is published every day and is a very useful summary of actions actually taken by the House.

B. Effective use of loose-leaf binder

Remind Delegates that there is a third delegate packet on-site, and that this packet includes an index and suggested organization of the binder. Since the chair uses the index to refer delegates to particular pieces of information during the proceedings, it is useful to organize the material before attending the first session of the House.

C. Use of Resource Persons

Experienced delegates have been assigned as resource persons to assist new delegates. The resource persons are available to "brainstorm" with delegates, answer questions, or generally facilitate the delegates' full participation in the House. Please remind the Delegates that since the President is the

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delegation's official spokesperson, it is difficult for the President to be drawn off into discussions of issues during the House Sessions.

D. Importance of effective caucuses

With 78 delegates, it will be difficult to answer all questions or entertain extensive discussions of issues during caucuses. Hopefully, Delegate Captains will give succinct reports of Reference Hearings and the Delegation can use caucus time to address substantive decision-making. Needs for information and assistance should be addressed to resource persons unless the full group requires the information or assistance. CAUCUSES ARE EXTREMELY TIME LIMITED.

IV. Evaluation of candidates

A. Identification of key issues

Delegates should be reminded that selection of officers is exceedingly important. Delegate teams will be asked to interview candidates about key issues and concerns and about candidates specific qualifications for office. If delegates have substantive information and/or recommendations about candidates this should be brought to the attention of the delegation at the caucus. Encourage delegates to review the insert in American Nurse which contains the candidates biographical information and statements of position.

B. Candidates forum

Encourage all delegates to attend the forum Sunday, 8-10 p.m. Delegates should be encouraged to take candidate bios with them to the forum since the specific qualifications of candidates may not be addressed in their brief verbal presentations.

C. Meeting with resource person before voting

Offer to meet with your group of delegates to discuss the candidates and strategy for voting.

V. Meeting with resource person

Offer to be available to meet with your cluster of delegates on the first day of convention and thereafter if needed.

7. Delegate Captains (Responsibilities)
8. Row Monitors (Responsibilities)
9. Assignment sheet
10. Guide for Interview of Candidates
11. Agenda for Orientation of New Delegates
12. Statement of Position and Rationale re Membership in SNAs
13. Parliamentary Guide

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THE NEW YORK STATE NURSES ASSOCIATION

DELEGATION TO 1988 ANA HOUSE OF DELEGATES

HOUSE OF DELEGATES PROCEDURES

Caucuses

Upon arrival at caucus, please sign attendance record, take your seat and come to order as quickly as possible. The caucus agenda will be full and must move very quickly. **Please be on time!**

House of Delegates

Upon arrival at the House, find your seat immediately. The seats at the ends of the rows assigned to NYSNA are reserved for those persons who have assignments as row monitors and delegate captains. (A seating chart will be made available.)

Row monitors and delegate captains have been assigned to facilitate the work of the delegation. Please see the attached description of their responsibilities.

Sign in at each session of the House with the row monitor at end of your row. Row monitors will distribute any additional hand-outs to you.

When you find it necessary to leave the floor during a session, please sign out with the row monitor and indicate where you will be and when you expect to return to the floor. This is essential in case you are needed for a vote.

REMEMBER

-bring all delegate materials with you to caucuses and sessions of the House of Delegates.

-be accountable and responsible for your attendance at delegate functions.

-if you must leave the delegation prior to closure of the House, confer with the Executive Director and leave your delegate credentials.

WMB/ker
5/24/88

THE NEW YORK STATE NURSES ASSOCIATION

DELEGATION TO 1988 ANA HOUSE OF DELEGATES

DELEGATE CAPTAINS

NYSNA Board members and past officers will be assigned in pairs to each end of each row of our delegates. One member of the pair should be present at all times during House sessions.

Responsibilities:

1. Assist delegates as needed by

   -answering questions re NYSNA positions
   -advising re procedures in House

2. Confer with President/Executive Director on recommendations to delegates - especially as new information/issues surface prior to a vote. Communicate strategy to delegates.

3. Assist with rapid communication between President/Executive Director and delegates of any information/suggestions to improve function of delegation.

4. Confer with other SNA delegations/representatives as requested by President. Report to caucus as requested.

5. Serve on delegate teams to report on hearings.

WMB/ker
5/24/88

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THE NEW YORK STATE NURSES ASSOCIATION

DELEGATION TO 1988 ANA HOUSE OF DELEGATES

ROW MONITORS

Row monitors will be assigned to each row of delegates and will sit at the end of rows, nearest President. One member of each pair should be present at all times during House sessions.

Responsibilities

1. Take attendance at beginning of each session of House of Delegates. Attempt to ascertain status of any absent delegate. Write down the following and deliver to E. Carter:

   .number of delegates present
   .absent from delegation
   name _____
   status _____

2. Please be prepared to count and report number of delegates present when necessary. (ANA's new electronic voting procedure will not eliminate the need for roll call votes. Any member of the delegation may call for a roll call vote at any time.)

3. One person in each pair of row monitors should attempt to locate and "retrieve" all delegates when it appears a vote is nearing (but not to the extent of being absent themselves when vote is taken).

4. Maintain sign-in/sign-out clipboards. Alert delegates who are leaving the floor to the possibility of a vote being taken.

5. Assist the delegation by obtaining any handouts being made available to the delegation. Put a handout at each delegates place and provide 2 copies to Martha Orr.

AMB:ker
5/24/88

THE NEW YORK STATE NURSES ASSOCIATION

DELEGATION TO 1988 ANA HOUSE OF DELEGATES

Barbara Backer
Pearl Skeete Bailey
Erika Baker
Sarah Beaton
Alice Hall Beck
Louise Bedford
Mary J. Bell-Downes
Nettie Birnbach
Patricia Bishop Barry
Mary X. Britten
Judith E. Broad
Leslie A. Brower
Frances Brown
Ellen M. Burns
Virginia B. Byers
Janet Cadogan
Mary Eileen Callan
Dorothy Carey
Elizabeth Carter
Jerold Cohen
Jessie M. Colin
Phyllis B. Collins
Karen Cool
Carol A. Countryman
Grace M. Daly
Constance Defreest
William R. Donovan
Judith Anne Evers
Susan J. Fraley
Anne Duval Frost
Louise P. Gallagher
Christina Gerardi
Miriam Gonzalez
Ann Gothler
Sr. Theresa M. Graf
Irmatrude Grant
William F. Greiner
Margaret M. Hardie
Shirley A. Hayes
Jean B. Heady
Carol B. Henretta
Juanita K. Hunter
Beverly R. Ianuzi
Ronald G. Inskeep
Martha Kemsley
Margaret Knight
Ruth Korn
Patricia Z. Lund
Barbara Malon
Glenda Marshall
Beverly Martin
Diana Mason
Elissa McDonald
Molly McGee Randist
Cecilia Mulvey
Madeline A. Naegle
Daphne Nelson
Veronica O'Day
Irene S. Pagel
Marlene Payne
Bonnie Perratto
Elizabeth Plummer
Kathleen A. Powers
Peter Prezioso
Richard W. Redman
Sr. Anne Reekie
Lois J. Ricci
Joanne M. Rooney
Irene L. Sell
Gale A. Spencer
Nancy Lee Sweeney
Greta Trotman-Jones
Charlotte Torres
Janice Volland
Kay Wiggins
Dorothy M. Williams
Marianne L. Woodard
Barbara Zittel

ker
6/7/88